State of Alaska
FY2011 Governor's Operating Budget

Department of Health and Social Services
Behavioral Health
Results Delivery Unit Budget Summary

Behavioral Health Results Delivery Unit

Contribution to Department's Mission

Manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships.

Core Services

- Provide for a continuum of statewide mental health and substance use disorder services ranging from prevention, early intervention, treatment, and recovery, including inpatient psychiatric hospitalization and operation of the Alaska Psychiatric Institute.

Results at a Glance

(Additional performance information is available on the web at http://omb.alaska.gov/results.)

END RESULT A: The quality of life for Alaskans experiencing a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance use disorder (SUD) is enhanced.

- In FY09, for each of three life domains (housing situation, physical health, and thoughts of self harm), more than 75% of individuals who received services through the comprehensive, integrated Behavioral Health Service System reported improvement or maintaining condition. For each of the remaining three life domains (financial/basic needs, meaningful activities/employment, and mental/emotional health), less than 75% of individuals reported improvement or maintaining condition.

  Status of Strategies to Achieve End Result
  - From FY07 to FY08, there was a 19.8% decrease in the number of distinct out-of-state residential psychiatric treatment centers (RPTC) recipients of care.
  - In FY09, 77% of the Annual Behavioral Health Consumer Survey adult and teen respondents reported a positive overall evaluation of services; 79% of parents/caregivers of youth reported a positive overall evaluation of services.
  - From FY08 to FY09, the reported number of enrollments into serious behavioral health disorder programs increased more than 20% for SED, SMI, and SUD programs.

Key RDU Challenges

Sustaining an Effective System of Care

The Division of Behavioral Health (DBH) business practice and management philosophy focus on the delivery of high quality services and demonstrated treatment outcomes. Achieving performance expectations for behavioral health service delivery relies on a viable and functional network of service provider organizations. Performance accountability systems require these providers to bear more risk for achieving results, as well as requiring changes of business philosophy, policy and clinical practice, with new resources and skills. However, this changing landscape presents significant challenges that place this service provider network at risk with negative impact on the quantity, quality, and effectiveness of services, including the potential of agency closure. Our system of care is fragile and requires the following:

- Business modeling that balances fiscal, revenue, and clinical management
- Personnel and workforce management that effectively recruit, train, and retain skilled employees (including equitable wages)
- Service provider data infrastructure for adequate equipment, skilled staff, and training
- Data-driven business management that optimizes data collection, reporting, analysis, and application to inform and modify business and clinical practices as needed

The division management and oversight of the system of care has developed “technical assistance” (TA) in response to these increasing challenges faced by the service provider network. Equally, successful outcomes will rely on commensurate division skills and resources.

Psychiatric Emergency Services

Psychiatric Emergency Services including on-call clinical response, evaluation and stabilization services and in-patient care when needed, comprise the most basic core services in the community behavioral health system.

Each community in Alaska, be it large or small, must have some capacity to respond to a psychiatric emergency. When behavioral health options are not available, the psychiatric emergency must be managed by primary care, with behavioral health backup, sometimes via technology. Component challenges are as diverse as the geographic disparity.

Rural-Frontier challenges include the ability for small village communities to coordinate services, so that the dignity of the person experiencing the crisis is respectfully preserved. This includes careful liaison with law enforcement, village-based peace officers, primary care practitioners and health aides. A greater emphasis must be placed on development of 'hands on' crisis intervention skills so that individuals can be stabilized in their own communities rather than being routinely transported to stabilization and treatment facilities in larger communities, including the Alaska Psychiatric Institute (API). Involuntary hospitalization is not only the most restrictive level of care in the service continuum; it is the most costly.

At the same time, we recognize that some individuals will require interventions or a level of care that cannot be provided locally. We must revitalize and expand our system of Designated Evaluation and Treatment/Stabilization facilities throughout the state, through increased outreach to the hospitals and increased support and training. When local hospitals assume these responsibilities, more than half of the individuals in crisis can be stabilized and returned home, without having to leave their community or region. Successfully stabilizing and treating people close to home also relieves pressure on API where the census is at or near capacity most of the time.

Suicide knows no boundaries in the state of Alaska. Prevalence rates are unacceptable, be it in urban, rural or 'bush' Alaska. Psychiatric Emergency Services is often the first responder in these crisis situations. It requires concerned citizens and the community at large to intervene in a suicide attempt, and there exists a need to train first responders in such situations.

Psychiatric Emergency Services is a part of the larger continuum of care, and is often a partnership between the mental health provider agency, law enforcement, primary care and hospital emergency department. Due to the disparity in resources across the state, the level of coordination and attention to clinically appropriate intervention strategies needs to be standardized.

As a result of a lack of Psychiatric Emergency Services in some areas of the state, admissions to the state hospital, API, have increased. During the first quarter FY10 API has operated with a 'pending admissions' list due to the lack of bed availability for acute care.

Behavioral Health and Primary Care Early Intervention Project

The publicly-funded health care system has very little to offer in the way of early intervention behavioral health services. Office of Children's Services cannot get families into brief solution-focused therapy, adults with substance abuse problems cannot get brief interventions, and many Alaskans who really need counseling are treated with medication only. Further, as our grantees are increasingly funded to serve consumers with sever problems, the centers are losing clinical skills in brief solution-focused therapy. Resources are needed to improve integration of behavioral health and primary care in order to identify best practices from other states, review possible regulatory changes to reduce barriers to integration, review financial implications of regulatory changes, collaborate between DHSS and primary care to facilitate general mental health services availability, and purchase services in non-urban facilities.

Prevention

The division's prevention and early intervention services section (CAPI) is striving to develop a clear, comprehensive and integrated approach to prevention of all behavioral health issues and those influences and causal/contributing factors that surround the behavioral health field (criminal justice, family violence [both child abuse and domestic violence], public health, primary health care, education and others). For too long we have segregated social and health problems into manageable but isolated parts, missing the powerful effects of a broad combination of interventions that can impact related and intertwined problems. We strongly believe that by combining our resources, our planning, our data and our

efforts, we will create a more flexible, accountable, innovative and measurable program. Issues of community readiness, coalition-building and leveraging critical partnerships, including our Alaska Native tribal health programs/corporations are key to developing a strong and sustainable continuum of care.

Suicide

Suicide in Alaska continues to be a critical concern; everyone in Alaska has been touched by suicide whether directly or indirectly. If we are going to make progress in reducing and preventing suicide in Alaska, we must work for better coordination, strategies, outcome measures and community planning and readiness. One of the first steps is to begin the conversation - in many communities, the impact and devastation of suicide has made it difficult to talk about; there is too much pain and loss associated with suicide, and many communities feel it is better to not talk about it. Suicide is an issue that requires community ownership, a commitment to discover and address the underlying influences, and developing positive strategies to change the social norm that allows suicide to be a viable option for too many individuals. A comprehensive, community and data-driven approach is necessary to begin turning the curve on the high rates of suicide across Alaska, especially in rural and remote Alaska and among our Alaska Native populations.

Performance Management System

The Division of Behavioral Health (DBH) business practice and management philosophy focuses on the delivery of high quality services and demonstrated treatment outcomes. A core function of the division monitors the service delivery system's performance, specifically in terms of the following: "Quantity" (How much did we do?); "Quality" (How well did we do it?); and "Outcomes" (Did anyone benefit?). Improving service through a results-oriented and performance-based approach requires changes in philosophy, policy and practice, as well as targeted resources.

- ***Performance Management System*:** DBH continues to develop and implement a *Performance Management System*, to insure an efficient, equitable, and effective system of behavioral health care for Alaskans. A performance-oriented system requires a correlate data infrastructure system. Related challenges involve budgeting for appropriately skilled research staff to maximize the necessary data collection, analysis, reporting, and application to business and service delivery practices. In addition, this system realignment absorbs a significant amount of leadership time and energy that limits our resources for new program development; we will need to address this shortfall in upcoming budget cycles.

- ***Information Management System Enhancement and Maintenance:*** The Alaska Automated Information Management System (AKAIMS) is the data collection and reporting system for the division's *Performance Management System*. AKAIMS has been successfully implemented with 100% of grantee provider agencies now submitting data to the division. The grantee provider-user network includes 70 agencies, with a combined individual user group membership of 1,965. Over the next year, expansion of the user group will expand by over 100 individuals from 30+ Behavioral Rehabilitation Residential facilities. System development, enhancements and maintenance of a management information system (MIS) is standard and expected business practice. Challenges involve budgeting for this standard life cycle of the MIS system with adequately skilled technical and training staff. In addition, this system realignment absorbs a significant of leadership time and energy that limits our resources for new program development; we will need to address this shortfall in upcoming budget cycles.

- ***Performance Based Funding (PBF):*** A key component of the *Performance Management System* is the method of distributing prevention and treatment funding, based on provider performance and outcomes (i.e. performance-based funding). Mandated by the 2007 legislature, PBF was successfully implemented by the DBH with significant positive outcomes in the management of the behavioral health system of care. As the sophistication of the PBF effort continues, the workload implications for current and future development is now better understood. Challenges involve budgeting for adequately skilled personnel for ongoing development, maintenance and application. In addition, this system realignment absorbs a significant of leadership time and energy that limits our resources for new program development; we will need to address this shortfall in upcoming budget cycles.

Significant Changes in Results to be Delivered in FY2011

Bethel Sobering Center and Community Service Patrol

The City of Bethel Community Service Patrol (CSP) and the Yukon-Kuskokwim Health Corporation Sobering Center is a collaborative project planned in FY08-09 and established in FY10. The project was designed to address the increasingly large numbers of inebriated people who have been picked up by the Bethel Police Department and transported to the

hospital emergency room and the Correctional Center for safety and Detox. The Bethel region was identified by the Alaska Mental Health Trust Authority and the Division of Behavioral Health as a target area for planning and implementation for specialized inebriate services. In FY11 Sobering Center services will be offered 12 hours per day, 5 days per week matching the CSP hours established in FY10. Screening, brief intervention, referral and treatment (SBIRT) are key components of the Sobering Center. Funds requested in FY11 provide annualized on-going support to sustain this community collaborative. Anticipated outcomes include: reduction of emergency room visits; reduction of CSP pickups; and reduction of lethal use of alcohol and other drugs.

Fetal Alcohol Spectrum Disorders (FASD)

During the past 11 years, the state of Alaska has made great strides in dealing with fetal alcohol spectrum disorders and the resulting disabilities from prenatal exposure to alcohol. In FY11, we are requesting additional funds to expand statewide diagnostic services, increase access to FASD treatment services for individuals and their families in rural Alaska, and increase substance abuse treatment services for pregnant women.

Through a Provider Agreement payment system, DBH pays our eight diagnostic team providers $3,000 per completed diagnosis. During FY10 and FY11 we anticipate the development of one new team in Anchorage (through Assets, Inc.) and the restart of former teams in Sitka, Dillingham, Copper Center and Ketchikan. Each of these communities had a team in the past, and suspended services due to staff changes and loss of critical team players. All four are currently working to re-establish themselves and begin offering services by FY11. Funds requested are to increase our current Provider Agreement fund allocation of $596,000 to increase the number of diagnoses by 20% and to enhance the current payment by $200.00 per diagnosis, specifically to cover the services of the required Parent Navigator. Currently Parent Navigators are the only team members who volunteer their time, without compensation. The additional $200 per diagnosis would cover approximately 10-15 hours of work by the Parent Navigator per individual diagnosis. These funds will:

- Increase regional capacity and access to FASD diagnostic services by 30% by FY12;
- Reduce the time between referral and diagnoses by 20% by FY12; and
- Increase the percentage of time Parent Navigators are able to spend with families before, during and after a FASD diagnosis has occurred, thereby increasing family understanding of the implications of the diagnosis and access to resources and services available to improve the outcomes for the individual with a FASD.

Increased Access to FASD Treatment Services in Rural Alaska: Access to adequate and appropriate services for individuals with a fetal alcohol spectrum disorder are limited across Alaska, but particularly so in rural and remote Alaska communities. Through these increased funds we will be able to:

- Target grant funds to build and maintain increased treatment capacity in those communities with an active diagnostic team so that children, youth and adults can receive appropriate therapies, services and accommodations as close to home as possible. Receiving a diagnosis is the first step to receiving appropriate services to improve the individual's long-term outcomes.
- Increase availability and utilization of occupational, physical and speech therapies;
- Reduce the number of children diagnosed with a FASD who are admitted to residential psychiatric treatment centers, including out-of-state placements; and
- Increase the knowledge, skills and competencies of all service providers who deliver services to children, youth and adults with a disability resulting from prenatal exposure to alcohol.

Finally, an increase in funds to have more treatment capacity available for women who are pregnant and continuing to drink but who are ready to stop, will provide a much needed boost to our FASD prevention efforts. Fetal Alcohol Spectrum Disorders are 100% preventable; if a woman does not drink during pregnancy, there will be no FASDs. But the reality of the addiction process is that, while it sounds good to say it is 100% preventable, alcohol is very addictive; women who want to stop drinking will need quality treatment services, designed to meet the needs of pregnant women, in order to prevent future FASD births. This increase in funding will decrease the time a woman must wait for treatment; it will encourage pregnant women to access treatment; and it will help reduce the FASD prevalence rate in Alaska. For

each child we prevent from having alcohol-related disabilities we save millions of dollars in social, medical, educational and other support services that would otherwise be needed over a lifetime.

Anchorage Secure Treatment Unit

The Secured Treatment Unit at the Salvation Army Clitheroe Center operates in accordance with Alaska Statute 47.37.030 (10). The program provides detoxification and residential substance abuse treatment services for adult public inebriates who are referred through emergency commitment procedures. Funding requested annualizes the cost of the pilot project which began in Anchorage in FY10 and was initiated by the 2007 Senate Bill 100. Anticipated outcomes include the following: reduction of emergency room visits; reduction of Community Service Patrol pick-ups; and reduction of lethal use of alcohol and other drugs.

Updated Status for Results to be Delivered in FY2010

Fairbanks Behavioral Health Enhanced Detox Facility

Significant Change in Result for FY2010:
Fairbanks is one of only five communities in the state with capacity to provide detoxification services for persons withdrawing from alcohol and drugs. This facility will serve not only Fairbanks itself, but also the Interior and Northern regions. The requested increment will close the funding gap for the new Detox facility, scheduled to open in January 2009. As a result of this program, Behavioral Health expects a dramatic reduction in the number of incapacitated individuals inappropriately (and expensively) held in jails and emergency rooms. Additionally, this project will ensure that the department meets its statutory responsibility: to establish a comprehensive and coordinated continuum of care for alcoholics, intoxicated persons, and drug abusers (AS 47.37.130).

Status Update for FY2010: Fairbanks Native Association (FNA) did open the new Enhanced Detox Facility in January, 2009 as planned. However, the program struggled for several months due to staffing and management problems, and closed temporarily in mid-summer to regroup and reorganize. DBH provided intense technical assistance during this time. Now FNA has hired an Advanced Nurse Practitioner and a Program Coordinator who is familiar with detox, so they expect to reopen soon. Also, they expect to reopen at the full 16-bed capacity which they had not achieved previously.

Grants for Community Based Substance Abuse Services

Significant Change in Result for FY2010:
Preventing and treating substance abuse is a department priority for FY10. The division received an increase in base funding for substance abuse treatment in FY09, which helped defray rapidly increasing costs. Additional funding in FY10 will allow the division to bring the continuum of care closer to meeting the actual demand; faster access to treatment services will reduce the impact of substance abuse disorders on the State's Court system, correctional facilities, hospital emergency rooms, and homeless shelters.

Currently, existing services for substance abuse disorder are unable to respond to the high demand for accessible substance abuse treatment services by the public and Courts. The State's largest treatment centers all have waiting lists of one to three months. Of particular concern are pregnant women with substance abuse disorders. Although the Federal Substance Abuse Prevention and Treatment Block Grant prioritizes treatment for pregnant women, some centers in Alaska simply cannot find room to accept women on demand. Behavioral Health anticipates increased access to treatment for Office of Children's Services (OCS) families, Severely Emotionally Disabled (SED) youth, therapeutic court clients, and inmates discharged from correctional facilities.

Status Update for FY2010: The division received a $1,250,000 dollar increment for substance abuse treatment services in FY10. The funds were designated for the following populations and services: $250,000 for Substance Abuse Treatment for the Office of Children's Services Engaged Families Program (Anchorage and Fairbanks only); $452,500 for Intensive Outpatient Treatment Services in Anchorage targeted to referrals from the Department of Corrections, Therapeutic Courts, the Division of Public Assistance, and clients with co-occurring disorders referred from Alaska Psychiatric Institute. The Division is soliciting for these services, with work to begin December 1, 2009. The balance of the increment is expanding detoxification services in the Anchorage area.

Grants to Community Behavioral Health Services [Severe Co-Occurring Disorders]

Significant Change in Result for FY2010:
Behavioral Health and the Alaska Mental Health Trust Authority (Trust) have identified a core group of adults with severe co-occurring disorders, who are especially hard to serve and to house. These consumers require more intensive services than 90% of their peers, just to keep them out of Alaska Psychiatric Institute (API), jail, and the shelters. The current level of community mental health center grant and Medicaid funding cannot adequately fund the intensive level of service this population needs. This increment will purchase additional intensive individualized services such as nursing care, 24/hour case manager support, daily medication administration, residential dual diagnosis treatment, and transport to services. At least 107 individuals can be served. The expected outcomes for this program include: decreased utilization of hospital emergency rooms, jails, and API, as well as increased consumer ability to function in the community and the workplace.

Status Update for FY2010: The division has initiated a limited grant solicitation process for Individualized Services Agreements (ISAs) for Adults with Serious Mental Illness (SMI). Provider agreements will be solicited from DBH grantees funded to provide services to SMI adults. These organizations' AKAIMS data will be used in post-payment review to monitor actual delivery of services and treatment outcomes. The ISA program will pay for clinic and rehabilitative services. It will also pay for some transportation and residential supervision costs to engage consumers, link them to services, and keep them safe in their homes.

Telebehavioral Health

Significant Change in Result for FY2010:
Alaska Psychiatric Institute (API) psychiatrists staff the API TeleBehavioral Health (TBH) Program, also called telemedicine, which provides 'real time' access to Alaskans who otherwise would have to travel to a regional hub for evaluation by a licensed practitioner. Approximately 40% of API admissions come from rural areas. With an average of 1300 annual admissions per year, this amounts to 520 admissions. Half (50%) of the aggregate rural admissions come from the Kenai and Mat-Su regional service areas. Over a three-year period, API will demonstrate a decrease in the referral rate for involuntary admission by having increased access to psychiatric evaluation and medication management services via telepsychiatry.

Status Update for FY2010: Those areas of the state, and specifically where the grantee utilizes the API TeleBehavioral Health services, have demonstrated a reduction in annualized admissions to API. This is most noticeable in Kotzebue, Dillingham and other Northern Regions. In Seward, creating greater access to services via technology has actually increased (temporarily) admissions to API due to case finding. Each admission was appropriate, and the TBH program remained active with each discharge in this community. In Seward, Kotzebue and Dillingham, the community providers of this program implemented 'live' discharge planning by linking the patient at API with the designated clinician and family members back in the community of origin.

The API TBH program has recently implemented a 'collaborative care' model that integrates behavioral health with primary care delivered through video-teleconferencing. Specifically, we have begun to assist Chugachmiut (Seward Clinic, Port Graham, Nanwalek) and Anchorage Neighborhood Health Center primary care providers in identifying and treating adults with depression and dysthymic disorder by offering a psychiatric consultation and liaison model as defined in the IMPACT (Improving Mood – Promoting Access to Collaborative Treatment) framework. The IMPACT framework is a SAMSHA evidence-based model practice.

We are planning to implement an "open access" clinic for rural clients to receive same day behavioral and psychiatric evaluations and treatment. The "open access" clinic will begin to perform behavioral health services during the first quarter of FY10. It is a replication of the open access model that is successful in primary care. Currently, over 200 remote sites across the state have connectivity to API. However, due to the small size in village clinic operations, rural sites cannot justify scheduled TBH clinic hours. The 'open access' model and its application to telemedicine will penetrate this market and area of need.

The telebehavioral health clinic has accrued over 1000 patient encounters since inception. Behavioral services have included adult and child psychiatric evaluations and treatment. Current participating sites include Chugachmiut, Council of Athabascan Tribal Governments Yukon Flats Health Center, Maniilaq Health Corporation, Seaview Community Services, Copper River Native Association, and Yukon-Kuskokwim Health Corporation. It is difficult, at this time, to provide first quarter FY10 data due to the transition to an electronic medical record.

Major RDU Accomplishments in 2009

- Funding received in FY09 for increased Alcohol Safety Action Program (ASAP) grant programs in Bethel, Seward, Dillingham, Nome and Barrow has increased ASAP juvenile programming. Programs are now functioning in Bethel, Seward and Dillingham; community planning has taken place in Nome, and an ASAP program will be starting in FY10. Barrow continues to address issues of community readiness to establish an ASAP program that will meet the needs of the community and meet the requirements of the ASAP program. ASAP staff continues to work with Barrow service providers.
- In an effort to increase ASAP client outcomes, we are moving to a system using Motivational Interviewing (MI) and Screening, Brief Intervention, Referral and Treatment (SBIRT). Toward this end, all of the ASAP Offices were provided with training in Motivational Interviewing and in FY10 we will continue with additional training in MI and SBIRT, to continue our transition to a program focusing more on client outcomes than just monitoring their compliance with court orders. This brief intervention focuses on increasing participants' insight and awareness regarding their substance use, and motivating participants towards behavior change, beginning with that first contact with the ASAP staff. The approach allows the ASAP staff to quickly assess the severity of substance use, identify the appropriate level of treatment, and to make appropriate referrals as needed.
- Provided services to approximately 8,443 seriously mentally ill adults.
- The division trained 75+ providers to improve their success at applying for consumers' benefits. Success of first time applicants rose from 40% to 75%, resulting in increased Medicaid benefits for adult consumers.
- In FY09 the Alaska Statewide Suicide Prevention Council (SSPC) moved from the DHSS Office of the Commissioner to the Division of Behavioral Health. This move has allowed for better coordination of statewide suicide prevention efforts between the SSPC and Behavioral Health. SSPC, Behavioral Health, and the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse work together for a consistent, comprehensive and coordinated effort to reduce and prevent suicides in Alaska. The SSPC continues to be a Governor-appointed board, and will be responsible for reporting annually to the Governor, Legislature and the department's commissioner. During FY09 a legislative "sunset" audit was conducted and a report was released at the beginning of the 2009 legislative session. The outcome of the sunset audit was the extension of the Statewide Suicide Prevention Council for four years through June 30, 2013.
- Preliminary FY09 data indicates that the Bring the Kids Home initiative continues to be successful in reducing the number of distinct out-of-state residential psychiatric treatment center (RPTC) recipients served, while the distinct RPTC recipients who received services in state is increasing. Between FY08 and FY09 there was a decrease of about 33.5% in the number of distinct out-of-state RPTC recipients of care and an increase of about 2.4% in the number of distinct in-state RPTC recipients of care.

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Behavioral Health
RDU Financial Summary by Component

All dollars shown in thousands

	FY2009 Actuals				FY2010 Management Plan				FY2011 Governor			
	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds
Formula Expenditures												
Behavioral Hlth Medicaid Svcs	53,530.7	79,601.6	66.3	133,198.6	49,540.9	90,771.4	2,217.5	142,529.8	54,974.1	95,373.5	2,217.5	152,565.1
Non-Formula Expenditures												
AK Fetal Alcohol Syndrome Pgm	1,292.8	0.0	0.0	1,292.8	1,468.5	0.0	0.0	1,468.5	1,697.1	0.0	0.0	1,697.1
Alcohol Safety Action Program	1,261.0	310.1	1,280.4	2,851.5	1,894.9	330.1	1,549.0	3,774.0	1,894.9	330.1	1,549.0	3,774.0
Behavioral Health Grants	8,944.0	3,164.5	14,727.6	26,836.1	10,689.2	3,320.2	17,233.4	31,242.8	12,982.5	3,320.2	16,708.4	33,011.1
Behavioral Health Administration	5,697.9	2,465.5	1,693.7	9,857.1	4,414.3	3,348.7	2,192.2	9,955.2	4,814.8	3,349.2	2,556.7	10,720.7
CAPI Grants	1,675.2	926.4	0.0	2,601.6	1,910.9	2,919.3	0.0	4,830.2	1,910.9	2,919.3	0.0	4,830.2
Rural Services/Suicide Prevent'n	398.3	20.7	1,948.8	2,367.8	434.8	500.0	1,986.8	2,921.6	434.8	500.0	1,986.8	2,921.6
Psychiatric Emergency Svcs	7,958.8	0.0	116.8	8,075.6	8,102.0	0.0	0.0	8,102.0	8,102.0	0.0	300.0	8,402.0
Svcs/Seriously Mentally Ill	12,460.7	710.0	1,170.0	14,340.7	13,618.7	989.5	1,300.0	15,908.2	13,868.7	989.5	1,100.0	15,958.2
Designated Eval & Treatment	2,908.1	0.0	0.0	2,908.1	3,867.3	0.0	300.0	4,167.3	3,867.3	0.0	0.0	3,867.3
Svcs/Severely Emotion Dst Yth	9,346.8	200.0	1,218.5	10,765.3	11,645.2	367.3	1,316.8	13,329.3	12,345.2	367.3	1,191.8	13,904.3
Alaska Psychiatric Institute	5,274.7	240.6	21,678.4	27,193.7	6,453.3	99.5	19,439.6	25,992.4	6,738.1	99.5	23,413.0	30,250.6
API Advisory	0.0	0.0	0.0	0.0	10.0	0.0	0.0	10.0	10.0	0.0	0.0	10.0

Behavioral Health
RDU Financial Summary by Component

All dollars shown in thousands

	FY2009 Actuals				FY2010 Management Plan				FY2011 Governor			
	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds
AK MH/Alc & Drug Abuse Brds Board	0.0	0.0	0.0	0.0	452.6	94.2	477.0	1,023.8	453.8	95.1	513.8	1,062.7
Suicide Prevention Council	51.3	0.0	0.0	51.3	82.8	0.0	0.0	82.8	82.8	0.0	0.0	82.8
Totals	**110,800.3**	**87,639.4**	**43,900.5**	**242,340.2**	**114,585.4**	**102,740.2**	**48,012.3**	**265,337.9**	**124,177.0**	**107,343.7**	**51,537.0**	**283,057.7**

Behavioral Health
Summary of RDU Budget Changes by Component
From FY2010 Management Plan to FY2011 Governor

All dollars shown in thousands

	General Funds	Federal Funds	Other Funds	Total Funds
FY2010 Management Plan	**114,585.4**	**102,740.2**	**48,012.3**	**265,337.9**
Adjustments which will continue current level of service:				
-Alcohol Safety Action Program	0.0	0.0	-138.0	-138.0
-Behavioral Health Grants	0.0	0.0	-725.0	-725.0
-Behavioral Health Administration	100.5	0.5	-410.5	-309.5
-Svcs/Seriously Mentally Ill	0.0	0.0	-1,300.0	-1,300.0
-Designated Eval & Treatment	0.0	0.0	-300.0	-300.0
-Svcs/Severely Emotion Dst Yth	-400.0	0.0	-1,200.0	-1,600.0
-Alaska Psychiatric Institute	-15.2	0.0	-46.6	-61.8
-AK MH/Alc & Drug Abuse Brds	1.2	0.9	-432.0	-429.9
Proposed budget increases:				
-AK Fetal Alcohol Syndrome Pgm	228.6	0.0	0.0	228.6
-Alcohol Safety Action Program	0.0	0.0	138.0	138.0
-Behavioral Hlth Medicaid Svcs	5,433.2	4,602.1	0.0	10,035.3
-Behavioral Health Grants	2,293.3	0.0	200.0	2,493.3
-Behavioral Health Administration	300.0	0.0	775.0	1,075.0
-Psychiatric Emergency Svcs	0.0	0.0	300.0	300.0
-Svcs/Seriously Mentally Ill	250.0	0.0	1,100.0	1,350.0
-Svcs/Severely Emotion Dst Yth	1,100.0	0.0	1,075.0	2,175.0
-Alaska Psychiatric Institute	300.0	0.0	4,020.0	4,320.0
-AK MH/Alc & Drug Abuse Brds	0.0	0.0	468.8	468.8
FY2011 Governor	**124,177.0**	**107,343.7**	**51,537.0**	**283,057.7**